



# Report of an inspection of a Designated Centre for Disabilities (Adults).

## Issued by the Chief Inspector

Name of designated centre:	Donegal Cheshire Apartments
Name of provider:	The Cheshire Foundation in Ireland
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	15 December 2021
Centre ID:	OSV-0003440
Fieldwork ID:	MON-0034478

## About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Donegal Cheshire Apartments provides full-time residential care and support to adults (male and female) with a disability from the age of 30 years old. The centre is a single storey dwelling that can accommodate up to twelve residents. Each resident has their own self-contained apartment comprising a kitchen, dining and lounge area and a bedroom with en-suite bathrooms which were accessible to people with mobility issues. There are also communal areas including lounge, two large activity rooms, two conservatories and additional bathroom facilities. The designated centre is located in a residential area of a town and is close to local amenities. Residents are supported by a team of social care workers along with additional nursing support being provided during the week. Residents are supported with their assessed needs by between three to four staff during the day and at evening times. Overnight there are two staff, one sleep over staff and one waking staff.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:

9

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

### **1. Capacity and capability of the service:**

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

### **2. Quality and safety of the service:**

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

**This inspection was carried out during the following times:**

Date	Times of Inspection	Inspector	Role
Wednesday 15 December 2021	11:15hrs to 15:45hrs	Alanna Ní Mhíocháin	Lead

## What residents told us and what inspectors observed

This was an unannounced inspection to monitor compliance with a number of specific regulations. The inspection was scheduled as a result of a number of incidents that had been reported to the Health Information and Quality Authority (HIQA) in line with the regulations. As the focus of this inspection was narrow, the building was not inspected and the inspector did not have the opportunity to spend time with all residents. The inspector adhered to public health guidance on the prevention of infection from COVID-19 throughout the inspection.

The inspector found that significant improvements were required in relation to the management and oversight of risk in the centre. The inspector noted inconsistencies in risk assessments and that not all identified control measures were implemented in the centre. Significant improvement was also needed in relation to staff training and the provision of food and nutrition to residents. These aspects of service delivery will be discussed later in the report.

In conversation with staff, it was clear that they were knowledgeable on the needs of residents in relation to their falls risk and support needed with eating and drinking. Staff reported that meal choices were offered to residents daily. Residents who chose to avail of delivery of precooked dinners to the centre could do so. Also, staff were available to support any resident who wished to cook their own meal in their apartment. Staff reported that residents were supported to draw up shopping lists. Staff checked food that was served to residents in order to ensure that it was in line with residents' swallowing recommendations.

The inspector met with one resident during the inspection. This resident reported that they were happy with the food that was available to them in the centre. Their main daily meal was ordered from a local shop and delivered to the centre. The resident reported that they were happy with this arrangement and found it preferable to staff cooking meals in the apartment. The resident reported that they received support from staff to order their meal from the local shop. The resident reported that they were reliant on staff to support them to complete their grocery shopping. The resident required assistance going to the shop or for staff complete the shopping on their behalf. The inspector discussed recommendations that had been made regarding the consistency of foods and fluids for the resident. The resident reported that they felt that these recommendations were unnecessary. The resident showed the inspector where food was stored in their apartment and it was noted that there was not enough food in the apartment that would allow the resident to make a snack or basic meal. The resident showed the inspector the call bell system that was in their apartment and were knowledgeable on how to use it if they needed support from staff.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in the centre and how these arrangements impacted on the quality and safety of the service being delivered to

residents.

## Capacity and capability

The focus of this inspection was the management of risk in the centre, specifically in relation to supporting residents who have swallowing difficulties and those at risk of falling.

Improvements were required in the area of management and oversight of risk in the centre. A review of documentation found inconsistencies in the identification of risks. Also, control measures to reduce risks were not fully implemented. Auditing of food and fluid consistencies was identified as a way of reducing risks to residents on modified consistency diet. However, this audit had not been completed. The management of risk will be further discussed in the 'Quality and Safety' section of the report. A review of the centre's policy on dysphagia (swallowing difficulties) found that not all aspects of this policy were implemented in the centre. The policy outlined steps that were to be taken in cases where residents did not choose to follow guidelines in relation to their swallowing. This had not been completed with one resident. However, the person in charge reported that times when residents chose not to follow recommendations had been logged in the incident management system. In addition, the policy required updating to reflect changes in the terminology used in the centre to describe the consistency of modified foods and fluids. The provider had identified the need for this update and the policy was due for review in the near future.

A review of staff training records found that not all staff were up to date on training in areas relating to falls management and supporting residents with swallowing difficulties. It was noted that three new staff were not trained in moving and handling and four existing staff required refresher training in this area. One staff member had not received training in this area since 2017. In relation to the training provided regarding swallowing difficulties, two new staff were not trained and four existing staff required refresher training. The person in charge reported that this module did not specifically train staff on how to prepare foods and fluids in line with recommended guidelines; yet, training in this area had been identified as a control measure on risk assessments in relation to supporting residents with swallowing difficulties.

Overall, it was noted that improvements in the oversight of the systems to control for risks was required in this centre. Policies and documentation in relation to risk required review to ensure that they were up to date and reflected the needs of residents. Staff required training in a number of areas relating to falls and swallowing difficulties.

## Regulation 16: Training and staff development

The provider had identified a number of areas of training as mandatory for all staff. A review of the training matrix found that not all staff were up to date in their training in relation to the support of residents with swallowing difficulties or with manual handling. In addition, staff had not been trained specifically in the preparation of modified consistency foods and fluids as identified as a control measure in risk assessments.

Judgment: Not compliant

## Regulation 23: Governance and management

Service reviews were conducted to identify areas for service improvement. However, not all audits that the provider had deemed necessary were conducted. The provider had policies in place to guide staff when supporting residents with their assessed needs. However, not all policies were up to date to reflect changes in the service. In addition, not all aspects of the policy reviewed were implemented in the centre. There was inadequate oversight on the assessment and control of risk in the centre in relation to supporting residents with swallowing difficulties and residents at risk of falling.

Judgment: Substantially compliant

## Quality and safety

This inspection identified that significant improvements were required in relation to the management of risk in the centre. In addition, improvements were required in relation to the provision of food and nutrition to residents.

The provider had a risk register in the centre that identified risks to residents, staff and visitors. In addition, residents had individual risk assessments in their personal folders. Control measures to help reduce the risk had been identified.

A review of the risk register found that there were inconsistencies in the assessment of risk. For example, the risk of choking was rated as low, yet the risk assessment in relation to 'Feeding, Eating, Drinking and Swallowing' was rated as very high. In addition, not all control measures identified in the risk assessments were implemented. For example, auditing of food and fluid consistencies was identified as a control measure in managing risks for residents on modified consistency diets.

However, this audit had not been completed. Staff training was also identified as a control measure but not all staff were trained in supporting residents with swallowing difficulties or in preparing modified foods and fluids, as outlined in the previous section.

Similar improvements were needed in individual risk assessments. For example, for one resident, the risk of falling was elevated to very high despite added control measures and no recent history of falls. In addition, identified control measures were not fully implemented. In this case, half hourly checks were to be completed to reduce the risk of falls but a review of documentation found that these checks were only completed hourly.

Not all risks were identified and assessed by the provider. A review of documentation and conversation with staff found that one resident did not always follow the guidelines in relation to modified consistency foods and fluids. This had not been assessed by the provider to give guidance to staff in managing this risk. In addition, not all risk assessments had not been updated in line with the changing needs of residents. For example, one resident's risk assessment in relation to swallowing had not been updated following a review by a speech and language therapist resulting in a change to safe swallowing guidelines.

As outlined above, residents were supported by staff to buy and prepare food. In certain cases, residents chose to buy precooked meals from a local shop. This included some residents who had recommendations in place regarding modified consistency foods. Staff reported that the consistency of food was modified in the local shop and that staff in the centre checked the food to ensure that it complied with the recommended food consistency guidelines prior to serving it to residents. Information sheets that gave descriptions of the appropriate consistency of foods were in the personal plans of residents who had been assessed by a speech and language therapist. However, there were no guidelines or documentation to provide assurances that these checks were taking place or that the food was appropriate to the residents' assessed needs. There were also no assurances regarding the nutritional content of the food once it had been modified. All residents availing of the precooked meals had their main meal delivered to the centre at the one time every day and at the same time every day. For one resident, this meant that they had to reheat their meal everyday as it was delivered while they were at day services. If a resident did not like their meal or wanted a different option, another meal would have to be ordered from the shop. This was not in keeping with a person-centred individualised service. As discussed previously, the inspector found that one resident did not have sufficient food in their apartment to allow them to have a snack or refreshment if they so wished.

Overall, it was found that significant improvement was needed in relation to the management of risk in the centre and regards to the safe, person-centred provision of food and nutrition.

## Regulation 18: Food and nutrition



Residents were provided with options to have their meals prepared in their apartments or to purchase precooked meals. Residents were offered choice at mealtime. However, the provider did not have assurances that meals were prepared in line with residents' needs. Also, there was not sufficient food in one resident's apartment to allow for snacks and refreshments.

Judgment: Not compliant

### Regulation 26: Risk management procedures

The provider had not consistently assessed the risks in the centre. Identified control measures were not fully implemented. Risks were not reviewed in line with the residents' changing needs.

Judgment: Not compliant

## Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
<b>Capacity and capability</b>	
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Substantially compliant
<b>Quality and safety</b>	
Regulation 18: Food and nutrition	Not compliant
Regulation 26: Risk management procedures	Not compliant

# Compliance Plan for Donegal Cheshire Apartments OSV-0003440

Inspection ID: MON-0034478

Date of inspection: 15/12/2021

## Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant** - A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.
- **Not compliant** - A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

## Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

### Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>Moving and Handling refresher training has been organized for 20/1/2022 and 25/1/2022 for 6 staff who require it</p> <p>All outstanding staff who required refresher training in the IDDSI framework and who are currently working in the service have completed same.</p> <p>This training includes awareness of signs of feeding, eating, drinking and swallowing difficulties, The IDDSI framework and its application in the preparation of modified fluids and foods and the IDDSI Testing Methods which are intended to confirm the flow or textural characteristics of modified food &amp; fluids at the time of serving</p> <p>Each staff member will be audited on their modification of food/fluids by 28/02/2022.</p> <p>Monthly spot checks will be carried out by the Clinical Nurse Manager to ensure consistency of food preparation for residents with modified diets. Findings will be documented and required actions identified.</p> <p>2 x staff who were long term absent require training in First Aid. This has been arranged for 25/2/2022</p>	
Regulation 23: Governance and management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>A new Full Time Service Manager will be in position from 17th January 2022 and will be appointed as Person in Charge.</p> <p>The local Management team will comprise Service Manager, CNM1, Service Co-Ordinator</p>	

and Senior Support Worker from 17/1/2022

All residents with swallowing difficulties have had their risk assessments reviewed as of 12th January 2022 and these will be further reviewed in line with their risk ratings.

All residents at risk of falls have had their risk assessments reviewed as of 12th January 2022 and these will be further reviewed in line with their risk ratings.

The service management team will be supported in the oversight of risk management by the Regional Support Services Team and the management of risk in the center will be a standard agenda item of the Regional Services Support Team meetings, held quarterly, and will oversee risk ratings and reviews for high rated risks of 15 and above.

The Provider's red risk escalation process will continue to be used to escalate risks with rating 15 and above to the relevant senior managers within the organization.

The Provider's Dysphagia policy is under review and has an intended completion date of 28/02/2022.

Monthly spot checks will be carried out by the Clinical Nurse Manager to ensure consistency of food preparation for residents with modified diets. Findings will be documented and required actions identified.

Each staff member will be audited on their modification of food/fluids by 28/02/2022.

Any resident who is currently choosing not to follow SLT recommendations has been referred for SLT reassessment and is being supported to become informed of the risks associated with their decision as per Dysphagia policy.

Regulation 18: Food and nutrition	Not Compliant
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Outline how you are going to come into compliance with Regulation 18: Food and nutrition:

The Service has linked with an external food outlet used by some residents on 11th January 2022. The outlet has agreed to provide nutritional composition of any food provided to residents of the service. This information will be provided to the residents in an accessible/understandable way.

For any food delivered from outside the service where modification of food is required, it will continue to be tested at the time of serving using the IDDSI testing methods.

All residents are being consulted with again, in relation to their food choices, shopping preferences and timing of meals. Meal cooking and preparation in the service user's apartment will continue to be offered as a choice as part of health promotion and skills teaching.

The completion date for this consultation will be 31/1/2022 and the service will continue to work with residents to meet their requirements.

If a service user wishes to have support in preparing a shopping list, this will be completed & updated as new supplies are required. Frequency and location of shopping

will be according to the resident's wishes. Residents will be encouraged to keep suitable snacks and foods available according to their wishes, with the support of the local staff team.

A selection of snack foods, has been purchased and will be held centrally by the service and will be made available to residents in cases where they do not have provisions and are unable to access a shop.

A healthy eating awareness session will be organized for the next resident's meeting through Healthy Ireland

The Provider is implementing a healthy eating project via zoom for residents in various centers. A resident of the designated center is participating in the organizing committee and all residents in the center have the opportunity to participate.

Regulation 26: Risk management procedures	Not Compliant
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Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

The Donegal Cheshire Apartments Risk Register has been reviewed by the Provider and local management team to ensure all risks are up to date and ,and all local risks are aligned with the Provider's risk rating . Completion date was 10th January 2022. All risk assessments will be reviewed at a frequency in line with their individual risk ratings.

Control measures contained in risk assessments will be communicated to staff through a safety pause at daily handovers and through an update file with read and understood documentation required to be signed by each staff member.

Management will ensure control measures are being implemented through regular checks of all documentation where staff record implementation of control measures, e.g. half hourly checks, ensuring these are delivered as directed.

The Provider will implement additional oversight measures, through monitoring the outcome of audits of care delivery, review of adverse events, file audits, review of communication notes, complaints monitoring.

Where control measures are not being implemented as directed this will be identified with staff at handovers and staff team meetings.

If individual staff are identified as failing to follow control measures then this will be raised with them individually through supervisions to determine their understanding and any additional supports required.

All Adverse events are reviewed by the Service Manager or designate and inputted into the Provider's portal system where they are reviewed and risk rated by the Regional Clinical Partner or the National Health & Safety lead as appropriate. Where further action is identified, or clarification required the Service Manager is contacted and relevant follow up actioned.

A red risk escalation process is in place for the escalation of highly rated risks in line with the Provider's risk management policy and ensures Senior Management are aware and

can provide advice and supports as required.

## Section 2:

### Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	25/02/2022
Regulation 18(2)(d)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.	Not Compliant	Orange	25/02/2022
Regulation 18(4)	The person in charge shall ensure that residents have access to meals, refreshments and snacks at all	Not Compliant	Orange	31/01/2022



	reasonable times as required.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/01/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	28/02/2022